Maine Health and Human Services
Elder Services
11 State House Station
Augusta, Maine 04333-0011

John Elias Baldacci, Governor

MaineCare Home Health Referral Attachment (Age 21 and over)

Member: _____ MaineCare #: ☐☐☐☐☐☐☐☐☐☐

Section 40.02-3

☐ Attached is the Form HCFA-485 Plan of Care signed by the member's physician. **OR**

☐ Attached are physician orders for the plan of care at time of discharge. The member is located in a hospital. **AND**

These services are not available and safely accessible to the member on an outpatient basis. Outpatient services are medically contraindicated with likelihood of a bad result.

Specify reason: _____. **AND**

☐ The member's condition requires **skilled nursing care** on a "part-time" or "intermittent" basis.

☐ The member's condition requires **physical or occupational therapy** as defined in Section 40.02-3(E)-13. Attached is physician documentation of person's rehab potential. Required therapy is related to the following episode (one of the following must be checked):

- ☐ treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities.
- ☐ treatment after a surgical procedure performed for the purpose of improving physical function.
- ☐ treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-6) with at least one person physical assist (defined in Section 40.01-16) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.

☐ The member's condition requires **speech therapy** as defined in Section 40.02-3(E)-14. Attached is physician documentation of person's rehab potential.

Prior Authorization required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

- ☐ Member requires additional certification period for unstable medical condition for continued assessment and management as defined in Section 40.06-E. **Start of Care Date: ___/___/___**
- ☐ Member requires continued home health services.
- ☐ Prior Authorization is needed to add additional services to Section 17 plan of care.

Person completing this form: _____ Date: _____

Provider Name: _____

Physical Location of:
Office of Elder Services
442 Civic Center Drive
Augusta, Maine 04333-0011

(207)287-9200
Toll Free: (800)262-2232
Fax: (207)287-9229
TTY: (800)606-0215